

Instructions for Filing - Optometry TPA Certification

Access this form via website at: www.hawaii.gov/dcca/areas/pvl

APPLICATION FORM (OD-06)

Type or print **LEGIBLY** in dark ink and sign the application. **Attach** appropriate fee and supporting documents.

FEE

ATTACH \$25.00 check made payable to: COMMERCE & CONSUMER AFFAIRS.

The application fee is not refundable.

Note: *One of the numerous legal requirements that you must meet in order for your certificate to issue is the payment of fees as set forth in this application. You may be sent a license certificate before the check you sent us for your required fees clears your bank. If your check is returned to us unpaid, you will have failed to pay the required certification fee and your certificate will not be valid, and you **may not** do business under that certification. Also, a \$15.00 service fee will be charged for checks which are returned by the bank.*

If for any reason you are denied the certificate you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a certificate has been denied.

EXAMINATION

You must have passed the NBEO TMOD examination, or the NBEO Part II examination after January 1, 1993. **Submit** verification of passing if grades were not previously reported to the board. Contact the NBEO at 1-800-969-3926 for information on this exam or visit their website at: www.optometry.org/.

EDUCATION

Submit an original transcript or certificate of attendance indicating completion of a **100-hour** board approved course in the treatment and management of ocular diseases.

If you graduated from an approved optometric school after January 1, 1997, you may satisfy this requirement by submitting written verification from the optometric school that you completed at least 100 hours of education in the treatment and management of ocular diseases.

EXPERIENCE

Submit original "Verification of Preceptorship Hours" (OD-07) form(s) completed by a **licensed** ophthalmologist verifying at least **100** preceptorship hours. Preceptorship hours may be earned under the supervision of more than one ophthalmologist (duplicate form OD-07 as needed or request additional forms from the board). **Preceptorship hours must be earned after July 2, 1997.**

Upon approval of your application, you will be issued a pocket card with the TPA designation.

BIENNIAL RENEWAL

The TPA Certification becomes a part of your license, which expires on December 31 of each odd-numbered year. To renew your license, you will be required to submit 36 hours of Board approved continuing education in the diagnosis, treatment, and management of ocular and systemic diseases.

LAWS & RULES PUBLICATION

To obtain a copy of the board's laws, chapter 459, HRS, and rules, chapter 92, HAR, send a written request to: *Board of Examiners in Optometry, Commerce & Consumer Affairs, P.O. Box 3469, Honolulu, HI 96801.* Chapter 436B, Hawaii Revised Statutes, the Professional and Vocational Licensing Act should be read in conjunction with chapters 459 and 92. You are responsible for knowing and understanding the statutes and rules and any amendments made to them throughout your career.

The laws and rules are also posted on our website at: www.hawaii.gov/dcca/areas/pvl. Click on "Optometry".

MAILING ADDRESS

Mail all required items to:

Board of Examiners in Optometry
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

Deliver to office location at:

335 Merchant St., Room 301
Honolulu, HI 96813

Phone: (808) 586-3000

LICENSEE ADDRESS

Pursuant to Section 16-92-3, HAR, you are required to file your business address with the board and notify the board in writing of any and all changes within 30 days of the change.

**ABANDONED
APPLICATIONS**

Pursuant to HRS §436B-9 your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years. The failure to provide evidence of continued efforts includes but is not limited to: (1) failure to submit any required information and documents requested by the licensing authority within two consecutive years from the last date the documents and information were requested, or (2) failure to complete any additional requirements for licensure that remain after approval of your application, such as attempting to complete an exam requirement, within two consecutive years from the date your application was approved, or (3) failure to provide the licensing authority with any written communication during two consecutive years indicating that you are attempting to complete the licensing process. If an application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000, to submit your request.

APPLICATION FOR THERAPEUTIC PHARMACEUTICAL AGENT CERTIFICATION - OPTOMETRIST

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Read attached requirements & instructions before completing this form.

Name (First, Middle)		(Last)	FOR BOARD USE ONLY		Approved	Initials/Date
Residence Address (Include apt. no., city, state & zip code):					<input type="checkbox"/> \$25	
Business Address (Include suite no., city, state & zip code):					<input type="checkbox"/> 100 Hour Course	
Mailing Address (Include apt. no., city, state & zip code):					<input type="checkbox"/> 100 Hour Preceptorship earned after 7/22/97	
Other Names Used (including maiden name):					<input type="checkbox"/> TMOD Exam or	
Social Security No:			Phone No. Res: Bus:	Date TPA Effective:	License No.: OD-	

- Circle or underline answers; give details if required and attach pertinent documentation:
- Do you have a current unencumbered Hawaii Optometry license with the DPA designation?.....YES NO
Indicate your license number _____ OD-_____.
 - Did you successfully complete a 100-hour board approved course in the treatment and management of ocular diseases prepared and graded by an accredited School of Optometry?YES NO
 - Have you passed the NBEO TMOD examination (or passed the NBEO Part II examination after January 1, 1993)?YES NO
 - Did you acquire 100 hours of preceptorship under the supervision of a licensed ophthalmologist after July 2, 1997?YES NO
 - Has your license ever been revoked, suspended or otherwise subject to disciplinary action?.....YES NO
If response is "yes", explain on a separate sheet and attach court documentation on the date, place and type of conviction and/or disciplinary action.

Affidavit of applicant:

I hereby certify that the answers and statements contained in this application and the documents attached are true and correct. I understand that any misrepresentation is grounds for refusal or subsequent revocation of license and is a misdemeanor (Section 710-1017, Sections 436B-19, and 459-9, Hawaii Revised Statutes.) I further certify that I have read and will abide by the provisions of Chapter 459, Hawaii Revised Statutes, and Chapter 92, Hawaii Administrative Rules.

Date

SIGNATURE
OF APPLICANT _____

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Appln 454 \$25
Service Fee BCF \$15

VERIFICATION OF PRECEPTORSHIP HOURS

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PART I. TO BE COMPLETED BY APPLICANT

- A. Complete information in Part I only.
- B. Give form to person who will be certifying your preceptorship hours.
- C. Attach completed form to your application before it is submitted.

Applicant's Name (First-Middle-Last)

Optometry License No.

PART II. TO BE COMPLETED BY OPHTHALMOLOGIST CERTIFYING TO APPLICANT'S PRECEPTORSHIP HOURS

- A. Complete information in Part II only.
- B. After completing form, give back to the applicant.

Name (First-Middle-Last)

Dates of Preceptorship

Residence Address

Location of Preceptorship

Residence Phone

Business Phone

By my signature below, I certify that the above-named optometrist has completed _____ preceptorship hours of hands-on experience and training in the diagnosis, treatment, and management of ocular disease, and is competent to prescribe, dispense, and administer therapeutic pharmaceutical agents.

License Number

Signature

State of Licensure

Date